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ABSTRACT

Effects of participatory planning on internal consistency within the special education referral, planning and placement process and the Individualized Education Programs (IEP) were investigated. A stratified representative sampling procedure was used to select 114 handicapped students enrolled in one district's special education program. Referral information, psychoeducational assessment results and IEPs were reviewed and coded on 3 checklists which contained 16 different instructional areas. Results revealed the predictive power of various professionals and noted, among other findings, that assessment results provided by the educational diagnostician and the school psychologist do not provide predictive power in readng and mathematics. Among recommendations made were that students should be assessed at least in those areas for which they have been referred; and that present level statements, short-term objectives, and annual goals must be related to one another in some coherent fashion within instructional areas. (Author/CL)

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PARTICIPATORY PLANNING AND INTERNAL CONSISTENCY INVESTIGATED WITHIN THE SPECIAL EDUCATION REFERRAL, PLANNING AND PLACEMENT PROCESS AND INDIVIDUALIZED EDUCATION PROGRAMS

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ABSTRACT

Effects of participatory planning on internal consistency within the special education referral, planning and placement process and the IEP were investigated. A stratified representative sampling procedure was used to select 114 handicapped students enrolled in the special education programs of one district. Descriptive results and regression analyses were presented. Because of the standard error size caution in interpreting multiple RS was encouraged. Increased internal consistency seems essential to professional practice which approximate regulatory rhetoria in special education.

Data analyses were programmed and run by Dr. Crist H. Costa. His contribution to this paper is gratefully acknowledged.

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INTRODUCTION

Special education is defined as "specially designed instruction, at no cost to the parents, to meet the unique needs of a handicapped child" (Federal Special Education Regulations, 1977, 121a 14). Specially designed instruction includes instructional content and procedures; consideration for the sequence of learning tasks and the pace in presenting learning tasks must be reflected in specially designed instruction. For it to be special education such instruction must respond to the unique needs of each handicapped student. Unique needs are identified through a psychoeducational assessment process. Unique needs include curricula areas within which instruction is required and optimal instructional methods to be employed with each handicapped student.

Both specially designed instruction and unique needs initially are identified within the special education referral, planning and placement process. Within this process, referrals usually are initiated by classroom teachers. Referrals are reviewed by a multidisciplinary team (MDT); psychoeducational assessments are conducted and reported by MDT members; and, students' eligibility for special education is determined. An individualized education program (IEP) is developed for each handicapped student based upon psychoeducational assessment results. Collaboratively developed by parents, teachers and administrators, the IEP orchestrates unique needs, specially designed instruction and the educational placement/related services to be experienced by the handicapped student. Hence, an individualized education program results from the special education referral, planning and placement process.

Internal consistency and participatory planning guide IEP development within this process. Internal consistency refers to identifiable relationships among reason(s) for referral, content and the psychoeducational assessment and components of the individualized education program. Internal consistency is present when the

following questions are answered affirmatively:

1. Are assessment results related to the reason(s) for referral?
2. Is content of the individualized education program related to assessment results?
3. Are present level statements, annual goals, or short term objectives within an IEP related to one another?
4. Does the content of the IEP systematically vary in relation to program placement i.e., resource, self-control, out-of-district?

The presence of internal consistency has been investigated (Dickson and Costa, 1981). Internal consistency indicated by significant though low order correlations were reported in this study.

Participatory planning reflects the conviction that each person's work counts for something in relation to the work of others for the benefit of each handicapped student. Work performed by diagnostic personnel, administrators, general and special educators, and parents must be meaningfully organized and integrated. Diagnosticians who have identified unique student needs and proposed specially designed instruction must participate in developing each IEP. Administrators who allocate resources necessary to implement each IEP must participate in meetings at which the IEP is developed. Teachers selected for their capacity to provide specially designed instruction must participate in planning each IEP when they are expected to implement it. As consumers who signify the appropriateness of each IEP, parents must meaningfully participate in developing each IEP.

The effects of participatory planning on internal consistency are of interest here. The following questions have been investigated:

1. Which professionals, identified by role, provide psychoeducational assessment results to the Multidisciplinary Team?
2. Who participates in IEP meetings?
3. Which member(s) of the Multidisciplinary Team, identified by role, increase internal consistency between reason(s) for referral and psychoeducational assessment results?

4. Which participant(s) in the IEP meeting, identified by role, increase internal consistency between psycho-educational assessment results and IEP content?

5. Which participant(s) in the IEP meeting, identified by role, increase internal consistency among present level statements, annual goals and short term objectives within the IEP?

METHODOLOGY

One suburban Rhode Island school district enrolling 188 handicapped students participated in this study, A stratified representative sampling procedure was used to select 112 handicapped students. This stratified representative sampling procedure was used so that a profile of referral, psycho-educational assessment and IEP information could be constructed and shared with each special educator employed by the district. Class rosters for students receiving special education were acquired from the Special Education Supervisor. Students were assigned to strata based on program prototype and organizational pattern of the school within which the program was located. The sampling matrix is presented in Table I.

Table I

Sampling Matrix

	Resource	Self-Contained	Out of District	Total
Sr. High School	27/50			27/50
Jr. High School	12/24	6/6		18/30
Elementary	40/73	12/15	13/16	52/88 13/16
Pre School		4/4		4/4
Total	79/147	22/25	13/16	114/188

All written information related to the special education of these students was filed in the District Special Education Office. Each student file was carefully reviewed. Referral information, psychoeducational assessment information, and IEP content were coded on checklists. The following categories of instruction remained constant across the three checklists:

1. Reading
2. Information processing
3. Mathematics
4. Science
5. Social science
6. General academic
7. Social adaptation
8. Self-help skills
9. Emotional/behavioral
10. Physical education
11. Motor skills
12. Speech
13. Visual acuity
14. Hearing
15. Vocational/prevocational
16. Other

Contributors to the psychoeducational report and participants in the IEP meeting were identified by role. Roles included on psychoeducational assessment and IEP checklists are presented in Tables 2 and 3. Checklists employed in this study will be provided upon request.

Training was provided to full time graduate students and special educators on maternity leave who were employed as data collectors. Twenty-four handicapped students' files were reviewed and coded by two different data collectors. An inter-rater reliability coefficient of .875 was demonstrated across the three checklists.

RESULTS

Effects of participatory planning on internal consistency are of interest. The frequencies with which professionals provide psychoeducational assessment results to the multidisciplinary team are presented in Table 2. Note the frequency with which physicians provide results to the MDT; the presence of their results provide predictive power in five of nine instructional areas identified through regression analyses reported in Table 4. The frequencies of roles participating in IEP meetings are identified in Table 3. Again, those professionals who participate least frequently in IEP meetings provide predictive power for internal consistency from psychoeducational assessment results to IEP content in nine of fifteen instructional areas (Table 5).

Table 2

Assessment Results Reported to the MDT Team	
Professional Role	No. of students
Educational Diagnostician	45
School Psychologist	96
Classroom Teacher	5
Nurse	0
School Social Worker	18
Speech Therapist	32
Neurologist	2
Psychiatrist	11
M.D., General Practitioner	3
Other	37

Table 3

Participants in IEP Meetings	
Role	No. of Meetings
Regular Classroom Teacher	49
Special Education Teacher	92
Physical Education Teacher	1
Speech Therapist	26
Physical/Occupational Therapist	3
Other Therapist	2
Special Education Administrator	43
Principal/Assistant Principal	39
Day/Residential School Representative	3
School Psychologist	37
Guidance Counselor	30
School Social Worker	8
Student	9
Parent	86
Other	39
	467

Multiple regression analyses were performed (Nye, 1975) to identify those professionals whose reports and/or participation increased internal consistency. Results of regression analyses are presented in Table 4, 5 and 6. Those instructional areas within which limited internal consistency was demonstrated are not included in these regression analyses.

Table 4

Professional Roles and Internal Consistency from Referral Reasons to Assessment Results Within Instructional Areas

Role	Instructional Area	Multiple R	Standard Error	F Ratio
Neurologist	Reading	.31578	.30535	8.5285**
M.D., Gen. Prac.	General Academic	.22857	.48824	4.2446*
School Social Worker	Social Adaptation	.29464	.3890	7.3202**
M.D., Gen. Prac.	Self-help Skills	.25618	.21467	5.4084*
Psychiatrist	Emotional/Behavioral	.2284	.45864	4.2378*
School Psychologist	Physical Education	.29742	.10811	7.47257**
Speech Therapist	Speech	.51023	.28966	27.1005**
Neurologist & Other Professional	Visual Acuity	.5316	.2103	14.9687**
Other Professional	Other Instructional Areas	.2452	.4402	4.9245*

* $P < .05$
** $P < .005$

Table 5

Professional Roles and Internal Consistency from Psychoeducational Assessment Results to IEP Content Within Instructional Areas

Role	Instructional Area	Multiple R	Standard Error	F Ratio
Speech Therapist and SPED Admin.	Information Processing	.32627	.46431	6.6119**
Student	Mathematics	.19487	.45644	4.4211*
Physical/Occupational Therapist	Science	.18622	.23797	4.0288*
Physical/Occupational Therapist	Social Science	.20667	.22042	4.9969*
School Psychologist	General Academic	.2099	.4194	5.1619*
PE Teacher and Residential Rep.	Social Adaptation	.3807	.2651	9.4073**
SPED Admin and PE Teacher and School Psych.	Self-help Skills	.5769	.3025	10.7964**
SPED Admin. and Student	Emotional Behavioral	.3809	.4169	9.4195**
Residential School Rep.	Physical Education	.6013	.1483	63.433**
Other Professional and Physical/Occupational Ther. and PE Teacher	Motor Skills	.3480	.3891	5.0538**
Speech Therapist and Residential School Rep.	Speech	.3496	.3382	7.7272**
SPED Teacher and Residential School Rep.	Visual	.3276	.1533	6.6742**
Residential School Rep	Hearing	.2740	.1274	9.0930**
Residential School Rep. and Other Therapist and School Psychologist	Voc/Prevoc.	.4746	.2416	10.6619**
Physical/Occupational Therapist	Other	.2293	.3581	6.2202*

* $P < .05$
** $P < .005$

Table 6

Participants in IEP Meeting and Internal Consistency Within the IEP (PL, AO, STO)

Role	Instructional Area	Multiple R	Standard Error	F Ratio
School Psychologist	Reading	.2099	.4194	5.1619*
SPED Admin and SPED Teacher	Information Processing	.2823	.4860	4.8048*
Counselor	Science	.1895	.2802	4.1698*
Student	General Academic	.2001	.4905	4.6725
Speech Therapist and Student	Social Adaptation	.3173	.4033	6.2111**
Physical/Occupational Therapist and PE Teacher	Self-help Skills	.3579	.3199	8.1545**
Speech Therapist	Emotional/Behavioral	.1901	.4949	4.1995*
Residential School Rep.	Physical Education	.4833	.1972	34.1409**
Speech Therapist and Parent	Speech	.3701	.3090	8.8053**
SPED Teacher and Occupational/Physical Therapist	Visual Acuity	.3185	.2306	6.2675**
Student	Vocational/Prevoc.	.2348	.2896	6.5374*
Counselor and Principal	Other	.3567	.4213	8.0893**

* $P < .05$

DISCUSSION

Effects of participatory planning on internal consistency within the special education referral planning and placement process were investigated. A stratified representative sampling procedure was used to select 114 handicapped students enrolled in special education programs in one school district. Referral information, psychoeducational assessment results and IEPs were reviewed and coded on three checklists. Sixteen different instructional areas remained constant across the three checklists. Entries made/not made on these instructional areas provided indices of internal consistency. Assessment results provided by professionals and participation in IEP meetings provided indices of participatory planning.

Those professionals who provided assessment results on the fewest number of students possessed the most power for predicting internal consistency between reasons for referral and assessment results (Table 2 and 4). These results suggest the judicious acquisition of diagnostic information by medical specialists. A neurological evaluation may have been acquired to assess organic basis for particularly resistant reading problems or visual acuity problems. A general medical evaluation may have been acquired to assess medical basis for overall academic malaise. A psychiatric evaluation is required by Rhode Island Special Education Regulations to categorically classify students as behaviorally disordered. No immediate explanation for the predictive power of a general medical evaluation on self-help skills is available. Internal consistency between reason(s) for referral and assessment results are obvious with the school social worker in the social adaptation area, the school psychologist in physical education and the speech therapist in the speech area. The predictive power of roles in two of these areas also suggests appropriate assignment of diagnosticians to students

based upon referral reasons. Obviously a school social worker should acquire diagnostic information on students experiencing problems in social adaptation; similarly speech therapists should acquire assessment data on students experiencing speech problems. Why psychological results should provide predictive power in physical education is not immediately apparent.

That assessment results provided by the educational diagnostician and the school psychologist do not provide predictive power in the areas of reading and mathematics is of concern. In a previous study (Dickson and Costa, 1981) no significant relationships between reason for referral and content of assessment were demonstrated in the areas of reading and math and hence internal consistency was not present. Absence of internal consistency in reading and math seems to result from the use of standard assessment batteries which include measures of reading and math performance irrespective of the reason(s) for which students are referred.

Understanding the predictive power of participants in IEP meetings for increasing internal consistency from assessment results to IEP content requires attention to the frequency with which participants actually attended meetings. Illustratively, the physical/occupational therapist participated in only three IEP meetings yet provided predictive power in science and social science - instructiaonl areas usually not considered as within the purview of a physical/occupational therapist.

Conversely, high frequency participants like SPED teachers and classroom teachers do not possess predictive power for increasing internal consistency within instructional areas like reading and math. Again, the absence of internal consistency from assessment results to IEP content in reading and math minimize the predictive power of the most frequent participants in IEP meetings.

A variety of roles influence internal consistency within the IEP. Instructional areas like visual acuity, vocational/prevocational, physical education and science appear in IEPs with less frequency than to reading, math and emotional/behavioral areas. However, relationships among present level statements, annual goals and short term objectives may be strengthened through participation of identified professionals.

Given the size of the standard error in all multiple regression analyses reported interpretations about the predictive power of roles for increasing internal consistency must remain cautious. The predictive power associated with low frequency contributors of assessment results and low frequency participants in IEP meetings is cause for conservative interpretations.

To avoid questionable testing practices students should be assessed at least in those areas for which they have been referred. This is not consistently the case. To insure that specially designed instruction responds to unique needs such instruction must be based upon assessment results. This is not consistently the case. To insure that learning tasks are sequenced appropriately, present levels statements, short term objectives and annual goals must be related to one another in some coherent fashion within instructional areas. This is not consistently the case. A higher level of internal consistency is required for the contributions of specific professionals to be reliably identified. When specially designed instruction is provided in response to the unique needs of each handicapped student then professional practice will approximate regulatory rhetoric.

REFERENCE NOTE

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